

May 24, 2019

Darnell Weatherington Deputy State Fire Marshal State Fire Marshal's Office Division 1 Office 1005 Technology Park Drive Glen Allen, Virginia 23059

Mr. Weatherington:

Please find enclosed the Plan of Correction (POC) for the locations listed as "MAIN BUILDING", "DALE NORTH", and "BERMUDA WING NURSING STATION" for citations you issued on the annual Life Safety Inspection at the Health Care Center Lucy Corr that occurred on May 7, 2019. All items contained within the POC will be completed by June 11, 2019.

If you have any questions regarding the enclosed POC, please contact me directly.

Regards,

Renee Allen, Administrator

Rallen@lucycorr.org

(804) 706-5730

Printed: 05/21/2019 **FORMAPPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
	495079		B. WING _		05/07	7/2019	
IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832							
PREFIX (EACH DEFICIENCY MUST E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
Description of structubuilding with a constr Sprinkler status: Fully An unannounced rour Safety Code survey ver 2019, in accordance Regulation, Part 483: Term Care Facilities. for compliance using regulations. The facility with the Requirement Medicare and Medicare	truction type of II (112 y Sprinklered time recertification L was conducted on 7 with 42 Code of Fed: Requirements for L The facility was suthe LSC 2012 Exist dility was not in compute for Participation in aid. Town demonstrate Title 42 Code of e Safety From Fire.) The facility was not in compute for Participation in aid. The facility was not in compute for Participation in aid. The facility was not in compute for Participation in aid. The facility was not in compute for Participation in aid. The facility was not in compute for Participation in aid. The facility was not in compute for Participation in aid. The facility was not in compute for Participation in aid. The facility was not in compute for Participation in aid. The facility was not in compute for Participation in aid. The facility was not in compute for Participation in aid.	ife May deral long rveyed ting bliance n spaces enced cted and ors are	K 000	Corrective Action The detectors in rooms 220 & 225 A facility Incident & Accident Reprompleted for this finding. Identification of Deficient Practic Corrective Action All facility ceiling mounted smoke could be affected. The maintenance conduct a 100% audit of all smoke Any negative findings will be corrediscovery and a facility I&A form Systemic Change(s) Policy on inspection was reviewed changes are needed at this time. M staff will be in-serviced on the profinspection and frequency of smoke Monitoring The Maintenance Director is responsintaining compliance. Weekly will be done to monitor compliance findings will be corrected upon dis A facility I&A will be completed findings and all I&A findings will to the facility Quality Assurance C Completion Date: 6/11/2019	ce and detectors e staff will detectors. ected upon completed. and no aintenance per detectors. nsible for visual audits e. Negative scovery. for negative be reported		

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

nulllun

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Printed: 05/21/2019 FORMAPPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 IDENTIFICATION NUMBER: COMPLETED 495079 05/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HEALTH CARE CENTER LUCY CORR 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 347 Continued From page 1 K 347 CORRECTED * The smoke detector in room 225 was not properly mounted on its ceiling base. CORRECTED These observations were witnessed by the Corrective Action facility's Director of Maintenance. K 353 The sprinkler heads located in the 2nd floor K 353 | Sprinkler System - Maintenance and Testing pantry lobby and hallway has been cleaned. SS=E CFR(s): NFPA 101 The sprinkler in the dietician's office has been cleaned. A facility Incident and Accident form Sprinkler System - Maintenance and Testing has been completed to document these findings. Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance Identification of Deficient Practice and with NFPA 25, Standard for the Inspection, Corrective Action Testing, and Maintaining of Water-based Fire All other facility sprinkler heads may have been Protection Systems. Records of system design, affected. The maintenance staff will conduct a maintenance, inspection and testing are 100% visual inspection of all sprinkler heads. maintained in a secure location and readily Any unclean heads will be corrected available. immediately. A facility I&A form will be filled a) Date sprinkler system last checked out for any negative findings. b) Who provided system test Systemic Changes The facility policy on sprinkler head c) Water system supply source maintenance has been reviewed and no changes are needed at this time. Maintenance staff will Provide in REMARKS information on coverage be in-serviced on policy and procedure. for any non-required or partial automatic sprinkler system. Monitoring 9.7.5, 9.7.7, 9.7.8, and NFPA 25 The Maintenance Director is responsible for This REQUIREMENT is not met as evidenced compliance. Weekly, the Director or their designee will do random unit inspections for The automatic sprinkler system is not being sprinkler heads. Negative findings will be inspected on a regular bases. corrected immediately and a facility I&A form Based on observation the sprinkler system is not will be completed. Weekly audits and I&A being properly maintained. forms will be forwarded to the QA committee for tracking and trending. * On 7 May 2019 at approximately 1115 hrs. it was observed that the sprinkler heads in the Completion Date: 6/11/2019 second floor pantry lobby and hallway are coated.

Printed: 05/21/2019 **FORMAPPROVED**

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 495079 05/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HEALTH CARE CENTER LUCY CORR** 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 353 Continued From page 2 K 353 * On 7 May 2019 at approximately 1415 hrs. it was observed that the sprinkler heads in the Dietician's office are coated. These observations were witnessed by the Corrective Action facility's Director of Maintenance. The pins for UL300 fire extinguisher and the 10 K 355 Portable Fire Extinguishers K 355 pound extinguisher have been corrected and a SS=E | CFR(s): NFPA 101 facility I&A form completed. Portable Fire Extinguishers Systemic Changes Portable fire extinguishers are selected, installed. All kitchen area extinguishers may have been inspected, and maintained in accordance with affected and each will be inspected by NFPA 10, Standard for Portable Fire maintenance staff with negative findings fixed Extinguishers. immediately and a facility I&A filled out. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced Identification of Deficient Practice and bv: Corrective Action Based on observation and interviews the Portable Policy for extinguishers has been reviewed with fire extinguishers are not being properly no changes needed. Maintenance staff will be maintained. in-serviced on policy. On 7 May 2019 at approximately 1315 hrs it was Monitoring observed that the kitchen fire extextinguishers The Maintenance Director is responsible for are not being maintained. compliance. Weekly, the director or his designee will inspect all kitchen extinguishers. * The pin is pulled on the UL 300 fire extinguisher Negative findings will be corrected immediately in the kitchen. CORRECTED and a facility I&A form completed. All findings * The pin is pulled on the 10 pound ABC fire will be sent to the QA committee for analysis. extinguisher in the kitchen. CORRECTED Completion Date: 6/11/2019 These observations were witnessed by the facility's Director of Maintenance. K 363 Corridor - Doors K 363 |Corrective Action SS=E | CFR(s): NFPA 101 The following doors have been adjusted to

Doors protecting corridor openings in other than

hazardous areas resist the passage of smoke

and are made of 1 3/4 inch solid-bonded core

required enclosures of vertical openings, exits, or

Corridor - Doors

allow for them to latch:

2nd floor hallway door near room 501

Storage room by Chaplin's Office

Dale/Clover Hill door by sprinkler

control valve for the dry system

Accounting storage room door

Printed: 05/21/2019 FORMAPPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION A: BUILDING 01 - MAIN BUILDING 01 COMPLETED **IDENTIFICATION NUMBER:** 495079 05/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HEALTH CARE CENTER LUCY CORR 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 363 Continued From page 3 K 363 Continued from page 3 A facility Incident & Accident form was wood or other material capable of resisting fire for completed for these doors that did not latch. at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist Identification of Deficient Practice and the passage of smoke. Corridor doors and doors Corrective Action to rooms containing flammable or combustible All facility fire door could possibly be affected. materials have positive latching hardware. Roller Maintenance staff will inspect all facility fire latches are prohibited by CMS regulation. These doors for latching and will immediately correct requirements do not apply to auxiliary spaces that any negative finds to include completion of a do not contain flammable or combustible facility I&A form. material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors Systematic Changes complying with 7.2.1.9 are permissible if provided The facility policy and procedure have been with a device capable of keeping the door closed reviewed and no revisions are necessary at this when a force of 5 lbf is applied. There is no time. Maintenance staff will be in-serviced on impediment to the closing of the doors. Hold open the door inspection process. devices that release when the door is pushed or pulled are permitted. Nonrated protective plates Monitoring of unlimited height are permitted. Dutch doors The Maintenance Director is responsible for compliance. The director or designee will do meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other weekly random audits of facility fire doors for materials in compliance with 8.3, unless the latching. Any negative findings will be smoke compartment is sprinklered. Fixed fire corrected at the time of discovery. A facility window assemblies are allowed per 8.3. In I&A form will be completed and forwarded to sprinklered compartments there are no the QA committee for tracking and trending. restrictions in area or fire resistance of glass or frames in window assemblies. Completion date: 6/11/2019 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices. This REQUIREMENT is not met as evidenced bv: Based on observation and interviews, the fire doors do not provide corridors and storage areas with protection from smoke or heat. * On 7 May 2019 at approximately 1130 hrs. it

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 05/21/2019 **FORMAPPROVED**

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 COMPLETED **IDENTIFICATION NUMBER:** 495079 B. WING _ 05/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HEALTH CARE CENTER LUCY CORR** 6800 LUCY CORR BLVD **CHESTERFIELD, VA 23832** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 363 Continued From page 4 K 363 was observed that the fire door on the second floor at the end of the hall near room 501 does not latch. * On 7 May 2019 at approximately 1200 hrs. it was observed that the storage room door in the fine dining room next to the Chaplin's Office does not latch. * On 7 May 2019 at approximately 1445 hrs. it was observed that the fire door between the Dale Unit and Cloverhill Unit near the sprinkler control valve for the dry system does not latch. On 7 May 2019 at approximately 1130 hrs. it was observed that the self latching storage room door in the accounting office does not latch. These observations were witnessed by the Corrective Action facility's Director of Maintenance. The electric box located in the ceiling of the K 911 Electrical Systems - Other K 911 outside covered porch has been corrected. A SS=E | CFR(s): NFPA 101 facility I&A form was completed. Electrical Systems - Other Identification of Deficient Practice and List in the REMARKS section any NFPA 99 Corrective Action Chapter 6 Electrical Systems requirements that All 4 of our outdoor porches may be affected. are not addressed by the provided K-Tags, but The Maintenance Staff will do a 100% audit of are deficient. This information, along with the all porches for ceiling electrical box covers. applicable Life Safety Code or NFPA standard Negative findings will be corrected upon citation, should be included on Form CMS-2567. discovery and a facility I&A form completed. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced Systemic Changes The facility policy and procedure for electrical Based on observation and inspections, it was work has been inspected and no changes are observed that the Electrical Systems is not necessary. Maintenance Staff will be in-

properly maintained.

On 7 May 2019 at approximately 1100 hrs. it was

on a junction box in the ceiling of the second floor

observed that there is exposed electrical wiring

serviced on covering exposed electrical boxes

The Maintenance Director is responsible for

maintaining compliance. The maintenance

Monitoring

Printed: 05/21/2019 **FORMAPPROVED**

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 495079 B. WING 05/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HEALTH CARE CENTER LUCY CORR** 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832 (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 911 Continued from page 5 K 911 Continued From page 5 director or designee will inspect all porches porch (missing ceiling fan). CORRECTED weekly. Negative findings will be fixed if found and a facility I&A form completed and These observations were witnessed by the facility's Director of Maintenance. sent to the QA committee for tracking/trending. Completion date: 6/11/2019 K 923 Gas Equipment - Cylinder and Container Storag SS=E CFR(s): NFPA 101 K 923 **Corrective Action** Gas Equipment - Cylinder and Container Storage The cylinder containing Helium was secured Greater than or equal to 3,000 cubic feet and stored properly. A facility Incident and Storage locations are designed, constructed, and Accident report was completed. ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. Identification of Deficient Practice and >300 but <3,000 cubic feet Corrective Action Storage locations are outdoors in an enclosure or All cylinders in storage may have been affected. within an enclosed interior space of non- or The Director of Maintenance will conduct a limited- combustible construction, with door (or 100% audit of all stored cylinders. Any negative gates outdoors) that can be secured. Oxidizing findings will be corrected immediately and a gases are not stored with flammables, and are facility I&A report completed. separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of Systemic Changes noncombustible construction having a minimum The policy on storage of compressed gas 1/2 hr. fire protection rating. cylinders has been reviewed and no changes Less than or equal to 300 cubic feet were needed. Central Supply and Maintenance In a single smoke compartment, individual Staff will be in-serviced on the proper storage of cylinders available for immediate use in patient cylinders. care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be Monitoring stored in an enclosure. Cylinders must be The Central Supply Manager is responsible for handled with precautions as specified in 11.6.2. compliance. The Supply Manager will conduct A precautionary sign readable from 5 feet is on weekly audits to assure all cylinders are stored each door or gate of a cylinder storage room. safely and per policy. All negative findings will where the sign includes the wording as a

minimum "CAUTION: OXIDIZING GAS(ES)

Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders

Storage is planned so cylinders are used in order of which they are received from the supplier.

STORED WITHIN NO SMOKING."

be corrected immediately and a facility I&A

Completion Date: 6/11/2019

report filled out. All findings will be forwarded

to the QA committee for tracking and trending.

Printed: 05/21/2019 FORMAPPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED			
		495079		B, WING _		05/07	//2019	
HEALTH CARE CENTER LUCY CORR 6800 L			6800 LI	DRESS, CITY, STATE, ZIP CODE LUCY CORR BLVD TERFIELD, VA 23832				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 923	are marked to avoid in the open are prot 11.3.1, 11.3.2, 11.3. This REQUIREMEN by: Based on observation cylinders are not be secured. On 7 May 2019 at a observed that press warehouse next to the being properly secured.	d confusion. Cylinders ected from weather. 3, 11.3.4, 11.6.5 (NFINT is not met as evident on and interviews, pring properly stored a approximately 1330 hours ared. CORRECTED as were witnessed by the extractions of the drop down door a red. CORRECTED	PA 99) lenced essurized nd rs. it was ne re not	K 923				

Printed: 05/21/2019 FORMAPPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 06 - DALE NORTH		(X3) DATE SURVEY COMPLETED	
	495079			B. WING		05/07/2019		
					STATE, ZIP CODE			
HEALTH	CARE CENTER LU	CY CORR		ICY CORF ERFIELD,	R BLVD VA 23832			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETION		
K 000	INITIAL COMMENTS			K 000				
	Description of structure: The facility is 2 story building with a construction type II protected Sprinkler status: Fully Sprinklered An unannounced routine recertification Life Safety Code survey was conducted on 7 May 2019, in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety From Fire.)		cited Life May deral Long rveyed ting bliance					
K 353 SS=E	CFR(s): NFPA 101 Sprinkler System - I Automatic sprinkler inspected, tested, a with NFPA 25, Stan- Testing, and Mainta Protection Systems maintenance, inspe maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMARE		sting ms are ordance on, I Fire design, dily	K 353	Corrective Action The sprinkler heads at the Dale show have been cleaned. A facility Incide Accident report has been completed negative finding. Identification of Deficient Practice Corrective Action All sprinkler heads in the facility ma affected. A 100% audit of all sprink will be conducted by Maintenance's negative findings corrected upon dis and a Facility I&A report filed. Systemic Changes Facility policy and procedure for sprinspection and condition has been reand no changes are needed at this tim Maintenance staff will be in-service inspection and condition of sprinkle	nt and for this e and ay be ler heads taff and scovery rinkler eviewed me. d on		

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 05/21/2019 **FORMAPPROVED**

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 06 - DALE NORTH COMPLETED 495079 B. WING 05/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HEALTH CARE CENTER LUCY CORR** 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 353 Continued from page 1 K 353 Continued From page 1 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced Monitoring by: The Director of Maintenance is responsible for The automatic sprinkler system is not being compliance. The Director or his designee will inspected on a regular bases. conduct weekly random rounds on all units for Based on observation the sprinkler system is not the condition of sprinklers. Any negative being properly maintained. findings will be corrected at the time of discovery and an I&A report filed with the QA * On 7 May 2019 at approximately 1450 hrs. it Committee for tracking and trending. was observed that the sprinkler heads in the Dale Unit Bathing/Shower room on the right side on Completion Date: 6/11/2019 the entrance door are coated. These observations were witnessed by the facility's Director of Maintenance.

Printed: 05/21/2019 FORMAPPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - BERMUDA WING NRS STATION		(X3) DATE SURVEY COMPLETED	
		495079	·	B. WING		05/07	7/2019	
	PROVIDER OR SUPPLIER	JCY CORR	6800 LU	UCY CORF	STATE, ZIP CODE R BLVD , VA 23832	F		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)		REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE		
K 000 K 347 SS=E	building with a cons Sprinkler status: Full An unannounced ro Safety Code survey 2019, in accordanc Regulation, Part 48 Term Care Facilities for compliance usin regulations. The fa with the Requireme Medicare and Medicare and Medicare and Medicare wit Regulations, 483.70(a) et seq (Li Smoke Detection CFR(s): NFPA 101	cture: The facility is 2 struction type of II (11 ally Sprinklered coutine recertification Lay was conducted on 7 ce with 42 Code of Fee 33: Requirements for Lay. The facility was suring the LSC 2012 Exist acility was not in compents for Participation in icaid.	Life 7 May deral Long urveyed sting oliance n	K 000	Corrective Action The smoke detector in room 108 has A facility Incident & Accident form completed.			
	open to corridors as 19.3.4.5.2 This REQUIREMENT by: Smoke detectors maintained Based on observation of being properly in the control of the	ystems are provided in serequired by 19.3.6.1 NT is not met as evident and the properly inspection the smoke detector maintained. Approximately 1345 hrowing detector in roomounted on its ceiling because were witnessed by the sere witnessed	denced ected and ors are rs it was m 108 pase.		Identification of Deficient Practice Corrective Action All smoke detectors may have been A 100% audit of all facility smoke of will be completed and all negative fibe corrected and an I&A form comp. Systemic Changes Policy for detectors was reviewed at changes are needed. Maintenance streducated on detectors and inspection. Monitoring The Maintenance Director is respon compliance. Director or staff will do audits of smoke detectors and fix an upon discovery and complete an I&A the QA committee to track and trenduction. Completion Date: 6/11/2019	affected. detectors indings will bleted and no aff will be n sible for b weekly y issues A report for		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

adrinistrator

5/24/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 05/21/2019 **FORMAPPROVED**

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION A. BUILDING 05 - BERMUDA WING NRS STATION IDENTIFICATION NUMBER: COMPLETED 495079 05/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HEALTH CARE CENTER LUCY CORR** 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 347 Continued From page 1 K 347 facility's Director of Maintenance. K 363 Corrective Action K 363 Corridor - Doors The fire doors leading to the rehab department SS=E | CFR(s): NFPA 101 have been repaired so they will latch. A facility Incident and Accident report was completed for Corridor - Doors this finding. Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or Identification of Deficient Practice and hazardous areas resist the passage of smoke Corrective Action and are made of 1 3/4 inch solid-bonded core All fire doors may be affected, therefore a 100% wood or other material capable of resisting fire for audit of all fire doors will be completed by the at least 20 minutes. Doors in fully sprinklered Maintenance Director or his designee. smoke compartments are only required to resist the passage of smoke. Corridor doors and doors Systemic Changes to rooms containing flammable or combustible The policy for fire doors and their operation has materials have positive latching hardware. Roller been reviewed with no changes needed at this latches are prohibited by CMS regulation. These time. The Maintenance staff will be in-serviced requirements do not apply to auxiliary spaces that on the policy and inspection process. do not contain flammable or combustible material. Clearance between bottom of door and floor Monitoring The Director of Maintenance is responsible for covering is not exceeding 1 inch. Powered doors compliance. The director or their designee will complying with 7.2.1.9 are permissible if provided be responsible for weekly inspection of random with a device capable of keeping the door closed fire doors throughout the facility. Latching when a force of 5 lbf is applied. There is no failures will be corrected at the time of impediment to the closing of the doors. Hold open discovery and a facility I&A report completed devices that release when the door is pushed or and forwarded to the QA Committee for pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors tracking and trending. meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other Completion Date: 6/11/2019 materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.

TZQE21

19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,

Show in REMARKS details of doors such as fire

and 485

FORM CMS-2567(02-99) Previous Versions Obsolete

Printed: 05/21/2019 FORMAPPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			FROVIDEN/SOFFEIEN/CLIA		PLE CONSTRUCTION G 05 - BERMUDA WING NRS STATION	(X3) DATE SURVEY COMPLETED		
		495079		B. WING _		05/07	7/2019	
HEALTH CARE CENTER LUCY CORR 6800 L			6800 L	DDRESS, CITY, STATE, ZIP CODE LUCY CORR BLVD STERFIELD, VA 23832				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
K 363 K 531 SS=E	protection ratings, a etc. This REQUIREMEN by: Based on observation of the protection from the with protection from the was observed that the Rehabilitation Service. These observations facility's Director of the Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with Elevators are inspected as ME A17.1, Safety Escalators. Firefight monthly with a written Existing elevators of 25 feet of the Existing elevators. All existing elevators are inspected as a comply with a written Existing elevators. All existing elevators are inspected by Code for Existing elevators. All existing elevators and existing elevators are inspected by Code for Existing elevators. All existing elevators are inspected by Code for Existing elevators. All existing elevators are inspected by Code for Existing elevators. All existing elevators are inspected by Code for Existing elevators. All existing elevators are inspected by Code for Existing elevators. All existing elevators are inspected by Code for Existence of 25 feet of level that best service as a complete of the code of the co	utomatics closing de IT is not met as evic on and interviews, the corridors and storal smoke or heat. approximately 1400 the fire door to the ces unit do not latch. were witnessed by the Maintenance. th the provision of 9. cted and tested as sp y Code for Elevators ter's Service is operate for record. onform to ASME/ANS sting Elevators and ing elevators, having or more above or below the needs of emerinting purposes, conformations.	denced e fire ge areas hrs. it he 4. Decified in and ted SI A17.3, a travel ow the gency orm with as service utomatic gency ke ectors.)		Corrective Action The phone in the elevator has been proposed to automatically dial an emergency esthat is manned by an operator. A facilincident and Accident report has been completed for this negative finding. Identification of Deficient Practice Corrective Action All facility elevators may have been and all negative findings will be corrective Indings Indings will be corrective Indings Indiagonal Ind	and affected. A ll be done ected and a phone has et that at all onsible for ignee will ny failure liately and		

Printed: 05/21/2019 FORMAPPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SU IDENTIFICATION		R/CLIA IBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - BERMUDA WING NRS STATION		(X3) DATE SURVEY COMPLETED		
495079			B. WING		05/07/2019			
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	STATE, ZIP CODE					
HEALTH CARE CENTER LUCY (JCY CORF						
CHESTERFIELD, VA 23832								
PRÉFIX (EACH DEFICIENCY MUST BE P	ENT OF DEFICIENCIE PRECEDED BY FULL F YING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
K 531 Continued From page 3 maintained. On 7 May 2019 at 1230 the Emergency phone in inoperative.	hrs it was observ	ved that	K 531		DPRIATE			